THE CANADIAN HEALTH CARE SYSTEM
Where Are We; How Did We Get Here?

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HPRU 91:10D

OCTOBER, 1991

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October 1991

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PART 1: AN HISTORICAL ACCOUNT

Canada's system of universal public insurance for health care is by a considerable margin the nation's most successful and popular public program. Far more than just an administrative mechanism for paying medical bills, it is widely regarded as an important symbol of community, a concrete representation of mutual support and concern. In a nation subject to strong divisive forces rooted in both geography and history, the health insurance system is an important unifying idea as well as an institution. It expresses a fundamental equality of Canadian citizens in the face of disease and death, and a commitment that the rest of the community, through the public system, which will help each individual with these problems as far as it can. "There is no social program that we have that more defines Canadianism or that is more important to the people of our country."¹

1.1 The Early Efforts (1930s and 1940s)

Although a national health insurance program had first been promised by the Liberal Party during the election campaign of 1919, and despite their success at the polls in that election, the first serious public discussion of public financing for health care really began on a national level in 1937. In that year the Report of the Rowell-Sirois Commission (Canada, 1937), an important Royal Commission which examined all aspects of Dominion-Provincial relations, recommended the development of "state medicine and state hospitalization or health insurance". It declared that such programs should be a provincial responsibility. These recommendations were to have a major impact on the thinking of future federal and provincial governments concerning the possible options for the creation of a "national" health financing program.²

Over the next eight years, there were several federal committees, of both politicians and public servants, to discuss the possibilities for public financing of health care. The Beveridge Report (1942) in the United Kingdom was very influential. These committees wrestled with some difficult questions.

First, since the Canadian constitution assigns health care matters almost exclusively to provincial jurisdiction, how would it be possible to create a program that all provinces would support or could afford? Would it be possible to achieve a constitutional amendment which would permit the

¹ David Peterson, the Premier of Ontario, opening the International Conference on Quality Assurance and Effectiveness in Health Care, Toronto, November 8-10, 1989. See also Evans, (1988a).

² The Commission rejected, however, the notion of large conditional federal grants directed to areas of provincial jurisdiction. Yet these conditional grants - 50 percent cost sharing by the federal government - were to be an essential component of both the hospital and the medical care insurance programs. In 1977 the federal contribution ceased to be based on program costs, but it remains conditional upon the conformity of the provincial plans to national standards.
federal government to mount the program?

Second, what would such a program cost? Although there were income tax data available about physicians' incomes and data from the Dominion Bureau of Statistics about hospital costs, no one knew what would happen to utilization following the introduction of public financing.

Third, how should revenue be collected? The "insurance" approach which was always envisaged would require some kind of poll tax. It was thought that this could be collected through employers, but what about the unemployed and the retired? The cost of having to register everyone and collect premiums was considered too complicated and costly. And who would pay for those would could not pay for themselves?

Fourth, should the program cover only the poor, leaving those would could afford it to cover themselves with voluntary, private insurance?

Fifth, what would be the reaction of the medical profession? The Canadian Medical Association (CMA) had also begun to debate the subject. Their first statement on the subject came in 1939 when they declared that they were not able to speak for their members on this because their members were not sufficiently familiar with such plans to take a position. However by 1943 they were ready to endorse two resolutions:

"1. The CMA approves the adoption of the principle of health insurance.
2. The CMA favours a plan of health insurance which will secure the development and provision of the highest standard of health services, preventive and curative, if such plan be fair both to the insured and to all those rendering the services." (Canadian Medical Association, 1943).

The doctors spoke of a preference for a plan which would have an income ceiling for beneficiaries. They also tended to favour a system of capitation payments for general practitioners and fee-for-service for specialists.

Sixth, what would be the reaction of business? A British Columbia proposal for a provincial program had been scuttled at the last minute due to the opposition of business leaders to a new tax. The insurance industry at that time endorsed the concept, provided that the plan was totally self-financing with the federal government paying for those who could not. Farm and labour organizations were strongly supportive.

Seventh, what would be the reaction of the provinces? In 1944 all provinces agreed to the concept of comprehensive public health insurance, but they stressed the need for each province to be free to introduce each benefit as it was able to do so.

Despite these difficult questions it is striking that the reports of the various government committees and the statements of the diverse interest groups during that period reflected a very high level of support for
comprehensive programs which would include, indeed would emphasize, preventive measures.

And so it seemed that by 1943 Canada was, after years of discussion, poised to introduce some form of public health insurance. However, throughout 1944 a series of federal/provincial disputes delayed the calling of the meeting planned to introduce the federal proposals. Thus it was that they became swept into the wide-ranging proposals for the post war reconstruction of Canadian society.

Finally, at the historic federal/provincial meeting in August 1945, the federal government unveiled its proposals. These included:

1. Immediate planning and administration grants to assist provinces in preparing to implement health insurance.

2. Provinces were to administer a universal, comprehensive compulsory, health insurance program which they would implement by progressive stages, according to an agreed-upon timetable.

3. The federal government would make a grant of 1/5 of the estimated cost of the service, plus 1/2 of the additional actual cost to a maximum of $12.96 per capita.

4. The federal government would provide additional health grants (to provinces that had implemented the program) for public health purposes.

5. The federal government would provide provinces with hospital construction grants.

Unfortunately, the entire conference collapsed due to the failure to reach agreement over the division of resources between the federal and the provincial governments, and the health proposals were left if not dead at least in limbo.

1.2 The Saskatchewan Hospital Insurance Program (1946)

Following the collapse of these efforts to establish a national program, the action shifted to the Province of Saskatchewan. This was the province hardest hit by the depression. The sparse population, scarce resources and dependence upon a single crop resulted in the development of cooperative agencies not only for the marketing of the wheat but also for the provision of essential social services. In fact, the cooperative movement flourished in Saskatchewan as in no other Canadian province, and this form of local initiative was to be extremely important in the history of health insurance in Canada.

Saskatchewan had already pioneered the municipal doctor schemes, in which general practitioners were employed, on salary, by rural municipalities. They also had a "union hospital" system which had (by legislation) grouped municipalities into districts for the purpose of building and operating
hospitals. Some municipalities had even gone beyond their responsibility for providing care for the indigent to begin collecting local taxes to pay hospital bills for all of their residents.

In 1944, in anticipation of the federal program the Saskatchewan government passed legislation to create a Commission to administer a health insurance program in the province, thus raising public expectations.

When the Premier announced, in 1946, the government's plan to launch the first comprehensive public hospital insurance program in North America, the province was suffering from severe shortages of health resources, including doctors, nurses, hospital beds and financial resources. There was fear that these resources would be completely overwhelmed.

Nevertheless, the Premier, Tommy Douglas, had a strong personal commitment to the enterprise. He was convinced that Saskatchewan would demonstrate the feasibility of public health insurance, thus facilitating the introduction of the national program and the transfer of federal resources to the province. As he said in the Saskatchewan Legislature,

"I made a pledge with myself long before I ever sat in this House, in the years when I knew something about what it meant to get health services when you didn't have the money to pay for it. I made a pledge with myself that someday if I ever had anything to do with it, people would be able to get health services just as they are able to get education services, as an inalienable right of being a citizen of a Christian country."^3

It appears that there was never any thought of introducing a program that would be less than universal and compulsory.

With respect to the benefits, it was decided, with the same underlying principle, that all essential hospital services should be covered and there should be no limit to the number of benefit days except the criterion of medical necessity. It was assumed that hospitals would continue to charge extra for private and semi-private ward accommodation, but that it would be necessary to ensure that there were an adequate number of standard rate beds available.

The initial cost estimates were made on the basis of existing hospital data and the estimate of utilization which had been agreed upon at the federal/provincial conference in 1945.

The major factor in the decision about the method of revenue collection was the requirement which had been proposed by the federal government of an "insurance" approach - that is, that a registration fee or premium be paid for each person covered by the plan. The government therefore decided to contribute an amount equal to what it had been contributing to hospitals prior to the program and to collect the rest through premiums.

^3 Quoted in the Regina Leader Post, 1 April, 1944.
How to pay the hospitals proved to be the most complex of the problems to be resolved. Certain principles guided the deliberations (Taylor, 1978):

1. The Hospital Services Plan would become the chief source of revenue for all hospitals in the province.

2. It would be impossible to permit a hospital to close through lack of funds.

3. The earning of a large surplus by any hospital would be undesirable.

4. A system of payment should be one which would encourage efficient operation and promote improvement in services. It must not subsidize inefficiency, waste or extravagance.

5. Additional payments by patients for "extras" should be kept at an absolute minimum.

6. Payment should be for operating costs only. Capital costs were to be borne by the community, with the assistance of provincial construction grants.

It was agreed that the most practical method of payment would be to pay the costs of operation, but initially this was difficult to determine because of the lack of standard accounting procedures, and so initially the hospitals were paid according to a point system in which hospitals were graded on the basis of their size and the services they provided.

Administration was assigned to the Health Services Plan Commission which was composed of public servants.

The Results

Initially the hospital utilization rate increased even more rapidly than expected and as a result the costs exceeded considerably the initial cost estimates. There were a number of important factors behind this: the shortage of physicians and the difficulties of transportation in the rural areas lead to a high rate of hospitalization; the health of the population was relatively poor because of poverty and large families; there were no alternative facilities such as nursing homes.

Nevertheless, the program survived these early difficulties, and within a year or two the plan was working well and the people of Saskatchewan were convinced that the decision to proceed without the federal government had been a good one.

All of Canada benefited from the Saskatchewan experience. It has been said that "in the educational process through which Canadian governments learned how to administer universal hospital insurance, Saskatchewan paid most of the tuition fees" (Taylor, 1978).
1.3 The Background to the National Hospital Program (1945-56)

Between 1945 and 1956, the federal government did not renew its health insurance offer to the provinces. However, in addition to the introduction of the Saskatchewan program there were some important developments. British Columbia introduced a similar program in 1949, but poor design and administration led to some serious early difficulties, and contributed to the defeat of the provincial government in 1952. In 1954 the new government terminated the effort to collect premiums through both payroll deductions and individual registration, and moved instead to financing from taxation. Alberta introduced a patchwork program in 1950, which required individual municipalities to opt into the plan, and then applied indirect pressure to force them to do so. Newfoundland, which became a province in 1949, brought with it its "cottage hospital system" which provided hospital and physician services to residents who paid an annual premium. The hospitals were provincially owned and the doctors were salaried. The system covered the population outside the urban centres (about 1/2 of the total population).

On the negative side, the CMA, in 1949, abandoned its earlier support for government health programs in favour of the extension of voluntary plans to cover all Canadians, with governments paying the premiums for those who could not afford them.

During this period there was also a rapid expansion of voluntary insurance enrolment.

Undoubtedly the most important development, however, was that Ontario with its great political clout assumed the leadership role in pressuring the federal government to deliver on its earlier promises of a national program.

By 1956 the federal action government was under strong pressure to act:

1. In 1952 a national sickness survey had demonstrated serious inequities with regard to health status and the financial burdens resulting from illness. These inequities applied both to socioeconomic groups and to geographical areas.

2. There were also serious disparities among provinces, with respect to their ability to provide needed health services.

3. There was growing political pressure from the public and the provinces for a national program.

On the other hand, there remained some important constraints, which included financial considerations, possible opposition from the Canadian Medical Association and the Canadian Hospital Association, both of which continued to argue for voluntary, private schemes with government subsidies for the needy. Finally there remained the complicated constitutional issues.
1.4 The National Hospital Insurance Program (1956)

Despite these obstacles, the federal government offered in 1956 to pay one half the national cost of diagnostic services and in-patient hospital care. Certain conditions were attached:

- coverage was to be universally available
- within an agreed time period diagnostic services were to be covered for out-patients
- co-insurance or "deterrent" charges were to be strictly limited
- capital costs were not included
- mental hospitals and tuberculosis sanatoria (which were already fully funded by provincial governments) were not included
- the federal contribution would be 25 percent of each province's shareable costs plus 25 percent of the average per capita cost for the whole of Canada (permitting poorer provinces to benefit more than the richer provinces)

These provisions were embodied in the federal Hospital Insurance and Diagnostic Services Act, passed in 1957, under which federal payments began to flow to provinces with conforming plans.

Ontario, the largest province, launched its plan for hospital insurance in 1959. Although nominally "voluntary", the Ontario plan was sufficiently favourable that within one year it covered 92 percent of the population and within two years 99 percent. In effect, the Ontario approach was quite similar to the Saskatchewan plan, achieving de facto universality without explicit compulsion.

One important difference at the outset was that at the time of its introduction, about two-thirds of Ontario residents had at least some protection against the costs of hospital care, mainly through the Ontario Blue Cross Hospital Plan, a subsidiary of the Ontario Hospital Association. One provision of the government plan was that it would take over the administrative staff and equipment of that organization, and it spent two years in strengthening that mechanism before launching the public plan. The Ontario Hospital Association agreed to limit its insurance activities to coverage for supplemental benefits such as the extra costs of private and semi-private accommodation.

In order to appease the Ontario Medical Association, the plan did not cover out-patient diagnostic services, nor did it include the innovative home care component which had originally been contemplated.

Because of the accumulated knowledge of the Saskatchewan program and the Blue Cross plan, the original cost estimates were much easier and more accurate. Standardized hospital accounting procedures made the
calculation of payments to hospitals much more straightforward than had been the case in Saskatchewan.

The Results

By 1961 all provinces had launched programs. With uniform conditions of residency, the same waiting periods for eligibility of new residents, and uniform benefits, ten provincial programs were melded into the reality of a national program.

To the surprise of many experts, public insurance did not accelerate the growth in hospital use. The rate of hospital inpatient days per capita rose only 13.7 percent between 1956 and 1966, compared with 27.2 percent between 1947 and 1956 (Barer and Evans, 1986). Clearly the main increase in utilization had already taken place - probably because of the voluntary plans in the larger provinces.

On the other hand, the decision to introduce hospital care as the first public insured benefit, and the failure to provide support for less expensive alternatives such as nursing homes, home care or ambulatory services, led to the perpetuation and extension of the pattern of inpatient use which had developed with the support of the private plans. By the mid-1960s, there was a growing recognition that a substantial proportion of inpatient use in Canada, as in a number of other countries, was inappropriate and unnecessary. Some services could be provided at less cost and equal or greater benefit in other settings; others, like excessive lengths of stay or inappropriate procedures, were simply unnecessary activity - pure waste. The public plans did not create this problem, but they did for a number of years ignore it.

Program financing, however, quite soon shifted away from the insurance model. By 1973 only two provinces, Alberta and Ontario, continued to require the payment of premiums as a condition for entitlement to hospital benefits.\(^4\) Today, only Alberta still levies premiums for hospital care, and as noted below, the federal legislation now clearly provides that coverage must be universal, and cannot be conditional upon payment (but see note 5 below). The other provinces finance their programs from general revenues collected through various combinations of income tax and sales tax. In effect the hospital "insurance" programs in most cases had become hospital "services" programs for residents.

1.5 The Saskatchewan Medical Care Insurance Plan (1961)

Once again the action shifted to the Province of Saskatchewan. The primary motivation for action was undoubtedly the philosophical commitment of the government, particularly of the premier, to the concept of health services as a fundamental human right. And the introduction of the

\(^4\) British Columbia abandoned hospital premiums in 1954, but continues to levy premiums for medical care. As of the end of 1991, a shift from premiums to some other form of tax is under active discussion.
federal hospital insurance program had produced a financial windfall for Saskatchewan. Furthermore, a local experiment in prepayment for medical care (the Swift Current region medical plan) had demonstrated the feasibility of a universal tax-financed program. In fact, it had resulted in the highest doctor to population ratio in rural Saskatchewan, where there remained severe shortages of physicians.

The major constraint, apart from the perennial problem of limited provincial financial resources, was the opposition of the medical profession, who "favoured health insurance but not state medicine" (Taylor, 1978). They considered themselves, through their College, as the body responsible for medical care in the province. Because of the chronic shortage of doctors and the mobility of physicians, they were in a very strong position politically.

The Physician-Sponsored Plans

In Saskatchewan, as in other provinces, there were physician-sponsored medical care insurance plans. These plans played an important role in the development of medical care insurance in Canada. They were voluntary, comprehensive plans which were often offered to individuals through their places of employment (with the result that they tended to cover the healthier members of society). Most of the plans were of the "service" rather than the "indemnity" type, that is, the doctor billed the plan directly, not the patient. Payment by the plan according to the fee schedule was generally accepted as payment in full; except in Ontario, physicians rarely billed patients for extra amounts. These plans institutionalized fee-for-service as the preferred payment method for the profession.

The Saskatchewan Medical Care Insurance Act

Despite the concerns about the possible reaction of the doctors, the press (which tended to be anti-government), and uncertainty about public reaction (since about 2/3 of the population had at least some voluntary coverage would the public countenance a major confrontation with the medical profession?), the Premier announced in December 1959 that the government would introduce a provincial medical care insurance plan.

There ensued two years of mainly acrimonious discussion and debate over the proposed legislation, but in late 1961, the legislation was finally passed.

The legislation provided that:

- the intent was to pay for services

- the administration would be the responsibility of a Commission of 6-8 members, of whom at least three were to be physicians

- there would be an advisory council representing professional and other interested organizations
- there would be a medical advisory committee with members approved by the College

- the program would be universal and compulsory

- the plan would be financed by premiums and general revenues

- insured services were all services of physicians and surgeons in office, hospital, or home

- with some minor exceptions, the plan payments were to be accepted as payment in full

- the patient was guaranteed the freedom of choice of doctor and the doctors were given the right to free acceptance or rejection of the patient

Despite its preference for a capitation system of payment for general practitioners, the government, in an attempt to appease the doctors, agreed to a fee-for-service approach.

It is impossible in this brief overview to discuss all of the debate which followed and the numerous proposals and counter-proposals which were developed by both sides during the next six months. The outcome was the worst episode in the history of health insurance in Canada. On 1 July 1962, the doctors began a strike which was to last for 23 days and which produced bitterness and rifts within the citizens of Saskatchewan which took a decade to heal.

The government had prepared for the possibility of a strike by recruiting sympathetic doctors from outside the province, mainly from Britain, but also from other provinces. The striking doctors were supported not only by the CMA and much of the provincial press (whose opposition was to the compulsory nature of the program), but also by many citizens, who through fear of losing their doctors or ideological conviction, organized "Keep Our Doctors Committees". These committees almost succeeded in forcing the government to concede defeat. On the other hand, much of the national media was favourable to the position of the government.

In the face of this impasse the government invited Lord Taylor, a British doctor who had been involved in the start of the British National Health Service, to come to Saskatchewan. He concluded that the plan was

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5 There was also considerable support for the doctors from south of the border. "The American Medical Association was at this time hysterically opposed to Medicare; and it endeavoured, not without some success, to communicate its hysteria to the doctors and the public in Saskatchewan." Lord Taylor, quoted in Taylor (1978). A successful public program in Canada might spread! The United States did launch its Medicare and Medicaid programs in 1965; and thirty years later, American interest in the Canadian system is again becoming intense.
basically a good one but that there had been insufficient early contact
with the doctors whose major concern was that they not become, in effect,
public servants. After negotiations which involved not only the
provincial government and the College representatives, but also
representatives of the GMA, he proposed a compromise which was accepted
finally by both sides - that the prepayment plans would remain in
existence. Doctors would have the option to enrol directly with the
government plan and be paid by it or to bill a voluntary plan which would
in turn bill the government, or to practise entirely outside these plans
(in which case their patients would be reimbursed by the government
commission if they billed in accordance with the fee schedule or not at
all if they did not). Initially most doctors did bill through the
prepayment plans, but over time the tendency was to bill directly to the
Commission.

The Results

In the immediate aftermath of the strike, there was a significant exodus
of doctors from the province, but within two years the
physician:population ratio was the highest ever, and physicians' incomes
had risen dramatically.

Once again Saskatchewan had demonstrated that a universal program was
feasible, albeit difficult to implement.

1.6 The National Medical Care Insurance Program (1966)

During the early 1960s another important event in the development of
Canadian health insurance took place - the Royal Commission On Health
Services, chaired by the Honourable Emmett Hall, Chief Justice of
Saskatchewan (Canada, 1964). The Commission released its report in 1964,
recommending that there be a:

"comprehensive, universal Health Services Program for the
Canadian people, based upon freedom of choice, and upon free and
self-governing professions; and financed through prepayment
arrangements;"

The report was a landmark document which spelled out in some detail what
form the program should take.

Again there were uncertainties about costs, provincial response,
opposition by the doctors, and response by the business community. Again
political leadership was an important factor. The Prime Minister, Lester
B. Pearson, who had a strong personal commitment to the concept, was
determined to have the program in place before Canada's centenary on 1
July 1967. Accordingly the federal government introduced its program in
1966. The legislation embodied four principles which had been presented
by the prime minister to a federal-provincial conference in 1965 (Taylor,
1978). The provincial plans must:

- be universal
- cover all medically necessary services of physicians
- be publicly administered
- provide for portability from one province to another

These "Four Points" evolved into the five basic standards applied today, and explored in detail below.

The Results

The legislation was not well received by some of the provinces, notably Ontario and Quebec, both of which objected on the grounds that the conditions (like those of the hospital insurance program) amounted to a federal intrusion into an area of provincial constitutional jurisdiction. Nevertheless, by 1971 all provinces had joined the program.

The transfer of financing from private to public sources necessitated the imposition of new federal and provincial taxes.

An important feature of the system as it developed was that private insurance for publicly insured services was prohibited in most provinces, making the emergence of a private system virtually impossible.

The Established Program Financing Arrangements (1977)

Despite the success and popularity of the hospital and medical care insurance programs, the federal and provincial governments had concerns about the financing arrangements. The federal government was frustrated by its lack of ability to control, or even to accurately predict, its expenditures on the two programs, since federal contributions were responsive to provincial expenditures. Moreover, the expected increases in public expenditures due to the end of uncollectible accounts and some increased utilization, were aggravated by factors which the insurance plans treated as beyond their control, including the the steadily rising physician to population ratio, expanding technology, and particularly rapid increases in the use of services by elderly people. Administrative costs, however, remained low.

At the same time, the provinces were demanding greater flexibility in the allocation of the federal funds. Discussions began in 1976 between the federal and provincial health departments about the possibility of extending the cost-sharing arrangements to "lower cost alternatives" such as nursing home care and home care.

In the same year negotiations began between federal and provincial finance ministers to develop new financing provisions. Eventually there was agreement on the fundamental change from cost-sharing to block funding, but not on the specific details. Finally in 1977 the federal government forced the provinces to accept the Established Programs Financing Act which ended the cost-sharing and provided for the provinces to receive a
combination of tax points and cash payments to the provinces. In return the provinces would have the freedom they had been seeking to spend the federal contributions as they wished provided that the basic conditions of the programs (universality, comprehensiveness, accessibility, portability, public administration,) were met. In addition, the provinces were given unconditional per capita grants for "extended health services".

Several provinces improved the availability and accessibility of home care and nursing home services; there has also been since the mid-1970s or earlier a slow decline in in-patient use. But in the subsequent years the federal government has three times moved unilaterally to reduce its obligations under the EPF formula, and in legislation passed in 1990 has implicitly established a schedule for phasing out its cash contributions entirely. 6

The Canada Health Act (1984)

In 1979, the federal Minister of Health became concerned over several aspects of the functioning of the provincial health insurance programs. She charged that the provinces were "diverting" funds provided for health care by the federal government through cash and income tax shares to non-health expenditures. 7 Moreover she feared that the imposition of user fees by provinces for hospital services, and extra-billing by physicians (direct charges to patients over and above the negotiated fee schedules), had reached the point where they were interfering in "reasonable access", one of the basic conditions of the federal program.

The federal government commissioned an independent review, again conducted by the Honourable Emmett Hall. This review rejected the claim that the provinces were "diverting" funds from health care, but supported the concerns about user fees and extra-billing. The government then introduced new health legislation to cover both hospital and medical care. It provided for financial penalties for provinces which permitted extra-billing or user charges, penalties which led to the effective elimination of both practices. It also consolidated and clarified the conditions of the earlier legislation.

6 This will not eliminate the federal contribution, at least in form, since the EPF arrangements of 1977 provided for transfers of both cash and a share of income tax revenues. Only the former is being phased out, but this may well have the effect of removing the federal government's ability to enforce national standards.

7 The provinces would of course have been entirely within their rights to do so. The change from cost sharing to block grants, forced by the federal government in 1977, placed no restrictions on how the provinces used their funds! They thus interpreted the federal claim as an attempt to embarrass them politically.
Once again, there was an angry debate involving the provinces and the doctors in opposition to the federal government. But the Canada Health Act finally passed in 1984, with the unanimous support of the federal Parliament. The extraordinary decision by the opposition Conservative Party to support this legislation was a bitter surprise for both doctors and provincial governments, and reflected the opposition's reading of the very powerful popular support for Medicare. After all, the normal duty of Her Majesty's Loyal Opposition is to oppose.

The Ontario and Canadian Medical Associations later launched a legal challenge to the legislation on the grounds that it was an unconstitutional intrusion into provincial jurisdiction, but withdrew the action in 1990 without coming to trial.

The implementation of a ban on extra-billing in Ontario led to a doctor's strike (the second in Canada) which lasted for 25 days in 1986. The lack of public support for the doctors finally caused them to abandon the strike, which had in any case not been well supported by the doctors themselves.

The major purposes of the Canada Health Act, the elimination of user fees and extra-billing, have thus been achieved, but its more ambitious objective of "protecting, promoting and restoring the physical and mental well-being of Canadians" will require more than the assurance of access to health services without financial barriers, as the continuing disparities in health status among socioeconomic groups illustrate.

1.7 Lessons From The Canadian Historical Experience

From the point of view of the general population, the Canadian health care funding system has been in existence in essentially its present form for over twenty years. For many it has "always been there" - a majority of the present population were born within the universal hospital insurance programs. The evolution of policy and legislation has had, over this period, very little impact on the individual patient or provider - or at least that they could observe.

The health care system does receive a great deal of public and political attention - there is always some sort of health "crisis" in the media. But this attention usually focuses on the immediate situation, and provides a misleading or erroneous view of the underlying forces at work. Providers of care constantly hammer the theme of "underfunding", meaning little more than that they would like more money, while provincial payers bemoan "cost explosions" and imminent system bankruptcy. All of this makes wonderful theatre, and sells newspapers; it is also ideal for the

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8 Taylor (1978) quotes a former federal minister of health, Judy LaMarsh, at the time of the debates over the federal Medical Care Act in 1966: "The opponents of medicare ... came out from their lairs again: the medical profession, the provinces, the medical care insurers, all of them." The same interests objected to the Canada Health Act in 1984.
exciting but meaningless two-minute television clip showing blood, emotion, and complex machinery.

In the second section of this paper we try to provide a somewhat more detailed assessment of the state of health care finance in Canada at the beginning of the 1990s - a mature, but evolving system. We will consider strengths and weaknesses, threats and promises, relative to the objectives of its architects, and those of today. But certain lessons also emerge from the historical record itself, independently of our current state, and it may be worth drawing these out first.

A. Things take a long time: It was roughly fifty years from the first serious discussions of health insurance at the national level, in 1943, until the last province entered Medicare in 1971. The process was very slow and contentious, and sometimes seemed to reach a dead stop.

B. The present tends to be much like the past: What was from one perspective a "radical" shift from private to public funding, can also be seen as a natural extension of well-established patterns of reimbursement (the original Blue Cross model of non-profit, service benefit, comprehensive coverage) to cover the whole population, within the same framework of private fee-for-service medical practice and independent non-profit hospitals. In contrast to the American experience, the Canadian public funding system has turned out to be highly "conservative" of the system of delivery.

C. If it is not fixed, it stays broken: When the Canadian provinces established universal hospital insurance, they inherited and extended excessively high rates of in-patient use. Changing the identity of the payer had no effect. Forty years later, while substantial progress has been made, there is still much overuse. The same inertia is observed in medical education. As we shall see below, Medicare began with a serious over-building of medical school capacity, which has yet to be reversed. And of course physicians themselves continue to be reimbursed primarily by fees for service, just as before.

D. Giving people things, is easier than taking them away: This applies particularly to providers of care, and of education. The right to serve (and be paid for it) seems to be an even more powerful political force than the right to be served. Thus it is much easier to expand a system, than to modify and manage it.

E. Thus there is an implementation dilemma: Getting through the slow and contentious process of acceptance and implementation will be easiest if minimal changes are made to existing arrangements. ("Revolutionary" approaches fail - at least in Canada.) But that strategy then freezes in place all the problems of the existing system.
F. **History does not stop**: While to the user, the Canadian funding system has been stable, the legislative, administrative, and funding bases have gone through major changes, and continue to evolve. And at each stage, the system has been attacked by the same economic and professional interests which resisted it from the beginning—physicians, conservative provincial governments, medical insurers, well-off individuals. The same old arguments recur, and must be refuted again and again. But since these arguments are rooted in a realistic appreciation of private interest, they will never go away.

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9 Private insurers have larger and more profitable markets in a private system, physicians make more money, wealthy individuals can buy preferred access when there are user charges.
PART 2: CENTRAL FEATURES OF THE PRESENT SITUATION

The Canadian funding system is, strictly speaking, not a national but a federal-provincial system, run co-operatively by the federal and provincial governments. The federal government has, with limited exceptions, no constitutional authority over matters of health. Thus the public insurance plans are actually operated by each of the provincial governments, which have full administrative and fiscal authority and responsibility. But the federal government makes substantial financial contributions to the provinces in respect of such plans (currently about 40% of total costs), on condition that the provincial plans conform to certain broad federally defined standards. It is thus possible to speak of, and describe, a "Canadian" system, even though each of the ten provincial plans has some distinctive features.

As described above, Prime Minister Lester Pearson in 1965 laid out four general principles which characterized the existing hospital insurance plans, and should apply to coverage of physicians' services as well. These have over time become refined and summarized as the five federal standards to which each provincial plan must conform, in order to qualify for federal contributions.

These standards - Universality, Comprehensiveness, Accessibility, Portability, and Non-Profit Administration - each represent a general principle whose intent is clear enough, but whose detailed application is open to considerable interpretation. They have been the subject of much discussion and some evolution over time. The Canada Health Act of 1984 has replaced and modified the earlier federal legislation (the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966) which originally served as the basis for the federal contributions, and it is the current source for interpretation of these principles. They serve as useful headings under which to describe the present system.

2.1 Universal Coverage

Universality was initially defined, when first the hospital and then the medical insurance programs were being phased in province by province, as "almost" all provincial residents (95%, rising over time to 99%). But it now requires 100 percent coverage of provincial populations. This is of particular importance in the two remaining provinces which still require their residents to pay premiums as part of the public health insurance system.10

10 "Premiums" have a rather peculiar history in the Canadian system. It was obvious to the designers of the public insurance system that universality was essential for a number of very good reasons - and they have of course turned out to be right. But this seemed to imply a compulsory system. The general population was in favour of universality - multi-class medicine and dumping the poor has never had much support in Canada - but were very ambivalent on compulsion and on balance seemed to be opposed. Physicians were, of course, ambivalent on universality and
Each provincial government is legally empowered to raise funds for the program any way it chooses, including through premiums. But the federal standards require that everyone in the province be insured. Thus no one can be denied services, or even charged for them, for failure to pay premiums.\(^{11}\) (Payment is legally required, and unpaid premiums are subject to collection, but payment is not a condition of coverage.) Hence the "premiums" are simply a form of poll tax, and the national income accountants have always treated them as such.

In the early years, however, there was some concern that very low risk individuals might still find it worthwhile to carry private insurance and stay out of the public plan. Since this would tend to defeat the purpose of risk-spreading over the whole population, by "creaming-off" the good risks, private insurance coverage for services covered under the public plan was not permitted. Private insurance persists for services not included under Medicare - dentistry, prescription drugs out of hospitals, and costs outside Canada above those reimbursable by the public plans - but (except for dentistry) these are relatively small amounts.

bitterly opposed to compulsion.

The compromise was a premium-based system in which provinces were committed to achieving "almost" universality by a combination of regulation and tax incentives. Premiums were uniform, not risk-related; all employers over a certain size were required to enroll their workers; competitive private coverage was not permitted; and the premiums were set well below actual cost with the difference made up from general revenue. In this way, de facto universality was reached without formal compulsion.

It was apparent almost immediately that premiums in a universal system were simply a regressive poll tax, costly to collect, covering only a small proportion of health costs, and moreover with certain technical disadvantages for provincial income tax collections. Thus by the early 1970s most provinces had scrapped them, and relied wholly on other tax revenues.

Three provinces with relatively right-wing governments retained premiums, however, and tinkered with them to make them less regressive by providing premium subsidies to lower income families. But they were never able to present any plausible reason for retaining this relatively expensive way of collecting taxes. The real reason may be ideological symbolism - some of their members and supporters were never reconciled to a truly "public" system, but could not say so openly. A change of government, from Conservative to Liberal, led to the abandonment of premiums in Ontario in 1990, and British Columbia is quite likely to do so within the next year or two, which would leave Alberta in isolation.

\(^{11}\) The federal law on this point is clear, but provincial practice is not. Most residents of the two provinces still levying premiums are unaware that they cannot legally become "uninsured"; and physicians are not reimbursed for services provided to those whose premiums are not paid up. Thus the premium system has become to some degree a barrier to access for certain groups in the population, despite the explicit requirements of the federal statute.
Nor is there any "private" system of health care delivery, operating side by side with the public plan. All physicians and hospitals, like all patients, work within the public payment system, but the delivery system is still from most points of view "private".

In some provinces it is still technically possible for a physician to withdraw from the public plan, and to see patients on a purely private basis, with neither being reimbursed by the public plan. A group of physicians could even set up their own, purely private, hospital or diagnostic facility, on whatever economic terms they chose. But their patients would have neither public nor private insurance; such care would thus appeal only to a very select group. Furthermore, the physicians in this situation could not simultaneously provide services to patients under the public plan. They must be "all in" or "all out". Thus private providers would have to be able to make a living purely in a private market, rather than playing both sides of the street as is common in European systems with a private system.

In consequence, no private market has developed, even where it is permissible. This suggests a more general principle, that "private" markets in medicine can persist only where they can be supported directly or indirectly by a public system.

2.2 Comprehensive Coverage

Comprehensiveness requires that provincial plans cover "all medically necessary" services. Such services as semi-private or private hospital accommodation, when not necessitated by the patient’s medical condition, or elective cosmetic surgery, are not included under the public plans. Similarly the services of non-physicians - optometrists, naturopaths, chiropractors, and other practitioners - are implicitly excluded from the federal definition of "medical necessity", and need not be covered. A province may cover other professional services of whatever type and on whatever terms it chooses; but the federal government imposes no conditions and makes no contribution toward such care.

The increasing interest in the effectiveness, or lack of it, of much contemporary medical care could conceivably infuse more content into the idea of "medical necessity". Many of the services provided by medical practitioners, and associated stays in hospital, appear to be in part or whole unnecessary. Strictly speaking, then, they should not be covered by the public plan. In practice, however, the test of necessity of a service has been (with very limited exceptions) that a properly licensed physician was willing to provide it, and a patient to accept it.

The concept of "medical necessity" might receive further consideration in future, if provincial governments decided simply to "de-insure" services of no demonstrable health benefit. Physicians might still offer such services as carotid endarterectomy or cardiac by-pass grafts for one or two vessel disease, but patients would be required to pay the full costs themselves.
At present, however, the trend is rather to try to develop improved regulatory mechanisms to deal with these issues, in co-operation with the leadership of the medical profession, rather than to raise the host of difficult and potentially explosive political and professional issues implicit in such a "market" approach.\(^\text{12}\)

Provincial governments have for years established temporary or permanent expert advisory committees, composed of both professionals from the community and bureaucrats, to review new technologies and make recommendations as to which new programs should be started, when, and where. Decisions as to how much capacity to add, become in effect decisions about the content of medical practice, since practice always presses against the limits of capacity. This form of "steering" of medical practice is as old as the public plans and older.\(^\text{13}\)

\(^\text{12}\) Certain services have always been excluded from the definition of "medical necessity" - elective cosmetic surgery for example, or health examinations for administrative reasons. Annual health exams are also known to be of no medical benefit and are excluded from coverage for the general population; certain types of immunizations are also covered only for high-risk groups. But when both patient and provider have an economic incentive, it is not very difficult to find some other reimbursable classification for such a service - an ordinary office visit, for example. Exclusion of inappropriate services would require one to delve much more deeply into the patient's condition, and second-guess the physician's decisions in individual cases, in a way which has rarely been done in Canada.

One might limit the reimbursement of physicians or hospitals when there is evidence of marked deviation, on average, from external standards. Provincial patterns of practice review committees already do this, in a small way, and the move to funding hospitals on the basis of the populations they serve would carry implicit penalties for overservicing. But the public identification of a doctor's decision as wrong, to the patient, among others, is political dynamite.

\(^\text{13}\) The constraints on capacity imposed by the provincial governments are two-fold. They supply (or do not!) both the capital funding for new equipment, and the operating funds for hospitals to use it. Contrary to the common allegations in the American press, these constraints do not lead to a failure to keep up with leading-edge technology, but they do limit its proliferation. The new and expensive equipment or program will be established in one or two sites, usually at a large health sciences centre, and access will be limited to those most likely to benefit.

Some physicians, and patients, who would like the new service, will not get it. There are not CT scanners on every street corner, or in mobile vans set up at shopping centres. But one hears a great deal from those who are denied access, whether or not the service would have been appropriate for their condition. One does not hear from the Americans who were provided with useless or harmful services - they do not know who they are. Again, the fundamental question is not, "Who has most?" but "What care is appropriate?" That question is not emphasized, however, either by
But increasingly such committees are being asked to make explicit recommendations about medical practice itself - guidelines for periodic health examinations, for Caesarian sections, endarterectomy, or cholesterol screening, to take some recent examples. Some provincial professional bodies are beginning to seek an active role in this process, others are hanging back, but it seems almost certain that the development of professional protocols, through some form of government and professional co-operation is going to be an expanding field.

The process is still at too early a stage to have much identifiable hard output. But there may be some emerging success stories. It seems increasingly likely that this consultation process will spare Canadians the gross excesses of cholesterol testing and therapy which are at present a growing threat to the health of the American population. On the other side of the ledger, careful evaluation by such a committee contributed to the rapid spread of effective therapy for hypertension.

What has not yet been addressed, is the issue of implementation. What does one do, when the protocols are not followed? No one, yet, has grasped this nettle, although there have been a number of suggestions of professional and economic incentives.

2.3 Reasonable Access on Equal Terms and Conditions

Accessibility has been a particularly contentious area, encompassing two major disputes between physicians and governments - extra-billing and hospital capacity. Do direct charges to patients impede access to needed care and violate the principle? And do attempts to moderate the expansion of beds and technology constitute a form of "rationing" which effectively does the same, even if care is "free". To date, the short answers given by Canadian opinion and practice to these questions are, "Yes", and "Not necessarily". The former question appears, for the moment, settled, but the latter is wide open and takes up a major share of Canadian political debate.

Extra-billing by physicians

On the first point, practice originally varied from province to province depending on the political strength of the medical associations at the time the medical insurance plans were introduced. In Quebec, at one end those who sell machines, or by those who are paid to use them.

Physicians have consistently sought the right to extra-bill above the fee schedule, and to impose other forms of direct charges on patients. Their objective is explicitly to increase the cost of a system which they claim to be underfunded. Yet simple-minded economic models assume that such charges will reduce overall rates of utilization and costs, and lower the incomes of the physicians who advocate them! Either physicians or neo-classical economists are very wrong in their understanding of the determinants of health care use.
of the spectrum, physicians who billed patients for amounts above the
negotiated schedule were not reimbursed at all by the public plan, nor
were their patients. At the other, in Alberta, physicians were free to
collect their official fees from the public agency and then extra-bill
their patients in any amount they wished - literally double-billing.
Other provinces permitted some form of extra-billing but on more or less
restrictive terms.

The Canada Health Act, however, provided that any provincial government
which either charged patients for covered services, or permitted anyone
to charge for them, would lose an amount from its federal grant equal
to the estimated total amount of such direct charges. Since that time,
all provinces have negotiated or imposed an end to extra billing, and
removed any other direct charges for covered services.15 The Act
responded to growing concerns and some evidence (hotly disputed by
physicians) that extra-billing was beginning to spread, and was becoming
an increasing impediment to access to care for those in greatest need.

How much access is reasonable?

The second issue is conceptually more difficult. Canada has historically
had a relatively large supply of hospital and other institutional beds,
and a correspondingly high rate of use. Nation-wide, there are about 6.75
public general hospital beds per thousand population, two-thirds in short­
term units and one-third in long-term units or extended care hospitals.
Days of care provided are about two thousand per thousand population, with
just over 60 percent in short-term units - a smaller proportion of days
because occupancy rates in short-term units average about 80 percent, in
long term facilities they are over 95 percent.

Students of health care utilization have generally concluded that the
Canadian pattern represents overuse, relative to medical need, and public
policy in all provinces has been, on balance, directed towards reducing

The comparison between the United States and Canada is suggestive,
since the former has the highest charges to patients, in the OECD world at
least, and the latter among the lowest. Yet it is in the U.S. that costs
are "exploding".

15 There is a significant exception to this penalty. Patients in
long-term care are provided with room and board, which they would
otherwise be paying for out of pocket. (Patients in acute care do not
usually give up their residences.) Since almost all such patients are
elderly, and on some form of public pension, the allowable charges are set
at a level to recoup most of the public pension, leaving a basic "comfort
allowance". The charges bear no relation to the actual cost of providing
care, which is met from public budgets.

"Prices" in this case are used as income distribution mechanisms, not
as ways of influencing use. Their focus is equity, not efficiency in the
economist's sense.
Similarly the introduction and dispersion of expensive new technical facilities and procedures has been restrained, through the public control of both capital and operating budgets in hospitals, and the negotiation process which determines what shall be included in the fee schedule.

Yet the supply of physicians has increased steadily, and this increase interacts with the rapid extension of technology to create a constant pressure for more and newer "tools of the trade". Physicians' incomes, in a fee-for-service environment, depend on their billing opportunities, and that in turn, for many specialties, depends on their access to (publicly provided) capital and associated (publically paid) nurses and technical staff. To this interest is now added a very powerful pressure from nurses and other hospital workers, for whom hospitals represent jobs and opportunities for professional advancement. These groups have become the loudest public voices demanding more beds, and larger budgets, and warning the general public of the threats to their health from "cutbacks". One observer has coined the phrase the "job fortress" to describe the Canadian hospital. Canada has in fact the world's highest rate of expenditure per capita, after the United States, and outlays have been rising more or less in line with national income over the past twenty years. But this is not enough for the providers of care, who look with envy at the ever-expanding share of income claimed by their counterparts next door in the United States.

It is generally agreed that "access" means, not the provision of all services imaginable, for everyone, but rather services according to need. The political struggle is then over the processes by which need is to be defined. To the medical profession, need is whatever a physician says it is. If that requires more, and more costly, services, then so be it. Someone - the government, the patient, the rest of the community - should raise the necessary funds. Governments, on the other hand, are increasingly arguing that the test of necessity is the demonstrable effect of intervention on health outcomes, effectiveness, not merely a physician's opinion, professional or otherwise. Furthermore, they are becoming increasingly aware of the large and growing body of research evidence which indicates that there is often little or no connection between the physician's opinion, and the demonstrated effectiveness (or lack of it) of the services provided.

Since this conflict between professional autonomy (and economic self-interest) and payers' concern for value for money (and economic self-interest) is a central issue in virtually every developed country in the

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Certainly the Canadian rates greatly exceed the corresponding American averages, which are themselves well above the experience of populations served by American Health Maintenance Organizations. Yet Canadian physicians continue to claim that they need more beds, and occupancy rates are near the limits of de facto capacity. There are similar concerns about overuse of hospital beds in a number of European countries, and similar efforts to reduce capacity.
Total Health Expenditure as Share of GNP
Canada and U.S., 1948-1989

1987-1989 data are preliminary
HPDP = Hospitals, Physicians, Dentists and Prescription Drugs
Hospital and MD Expenditure as Share of GNP
Canada and U.S., 1948-1989

1987-1989 data are preliminary
world, the application of the principle of access in the Canadian system is likely to remain contentious for a very long time to come.

2.4 Portability of Coverage Within Canada

Portability of benefits is an important principle in terms of its symbolism for national unity, but has not been particularly contentious. It is largely a technical problem. Political issues have arisen only in the one or two cases in which a metropolitan region spans a provincial border, or a significant region of one province receives its tertiary care from a large city in another. If the fee schedules are markedly different, either providers or payers may object to the financial transfers involved.

More potentially troublesome, is the issue of payment across the border with the United States. As noted in the discussion of accessibility, provincial governments limit the proliferation of hospital capacity and particularly of expensive diagnostic equipment, by funding them through hospital capital and operating budgets, not through fees per item of service. A hospital which wishes to acquire an MRI machine, for example, or a lithotripter, must not only receive planning approval from its provincial ministry of health, it must also convince the ministry to provide the capital funds. Private physicians can in principle purchase and use such equipment, but if there is no corresponding procedural item in the fee schedule, they cannot be reimbursed (by government or patient) for its use.

The result is that physicians claim a shortage of major diagnostic equipment, relative to the much greater capacity and use in the United States. (The price, however, does not fall in the U.S.!) Whether this represents a shortage in Canada, relative to the needs of the population, or a surplus in the United States, (or both) is another matter.

17 In some cases, hospitals have been successful in convincing private donors to provide funds or equipment, but then the hospital must find resources for increased operating costs within its global budget. Ministries usually resist providing increased operating resources for an unapproved capital expansion.

18 This is slightly too simple. Procedural fees for diagnostic services are usually divided into a professional and a technical component. An appropriately qualified physician can claim the professional fee for interpreting the diagnostic results, whether the equipment is owned by a hospital, a private facility, or his own practice. But if there is not also a technical fee component in the negotiated schedule, to pay for the equipment, technicians, reagents, etc., then in effect the equipment is not reimbursable outside the hospital. In addition, even when private facilities can be reimbursed for diagnostic services, there will be some form of additional licensure or other restrictions limiting those entitled to bill.
Portability outside Canada

One could imagine, then, an increased flow of patients across the border in response to the increasing gap between Canadian and American patterns of care. This would place provincial governments in the difficult position of either paying for such additional care, and thus losing control of their total outlays, or permitting the development of a de facto private system of care alongside the public, for those who can afford to pay the American price.

In practice, however, this does not seem to be developing as a significant problem, with the exception of one or two border cities, and one or two particularly contentious procedures. The reality of care use is that patients do not in general "demand" particular procedures; they seek the recommendations of their physicians. These latter can, and do, sometimes refer patients to the United States and then energetically publicize the incident as part of a continuing struggle with provincial governments over the availability of health resources. But this sort of political theatre does not correspond to any large movement of patients or dollars.¹⁹

2.5 Administration of Coverage by Non-Profit Agencies

Non-Profit Administration, the final principle, has drawn very little subsequent commentary in Canada, because in most parts of the country the private health insurance industry was relatively underdeveloped at the time the public plans were introduced. In each of the provinces there were not-for-profit insurers, sponsored originally by the hospital and physician associations, similar to the Blue Cross plans in the United States. The hospital and medical insurance business of these plans was simply taken over by the public agencies. In some cases the provincial plans continued to work through the previous carriers as intermediaries, but this arrangement was found to be both unnecessarily costly, and inefficient, and was soon terminated.

The historical and customary support for non-profit administration was strongly reinforced by the recommendations of the Report of the federal Royal Commission on Health Services (Canada, 1964), the massive investigation which pre-dated the extension of public coverage from hospital care to physicians' services. Justice Hall observed that the private insurance plans were paying out relatively low proportions of their premiums in benefits.

Studies for the Commission indicated that in the early 1960s administrative overhead absorbed about 22 percent of all premiums for private health insurance in Canada. This ratio was, of course, lower for the dominant group plans (20%) than for non-group plans (30%). But the

¹⁹ Such theatre can, however, have powerful political consequences. Life and death events are emotionally very gripping, and can have significant effects on the allocation of health care resources among particular programs.
plans offered by commercial firms which were just beginning to penetrate the market, providing more limited coverage and selecting the lower risk groups, had overhead rates of 30 percent for their group contracts, and a whopping 55 percent on the non-group (Canada, 1964, ch.18). This appeared not only inefficient, but unjust.

But the raison d'etre of a private company is to make profits, not to pay claims. A private insurer refers to the ratio of claims to premiums as the "loss ratio", to be minimized; profits and other expenses must be found out of the overhead share. To the rest of the community, however, the "loss ratio" is the proportion of total payments to the insurer which actually goes to pay for the desired services, as opposed to being taken up in overhead costs. Thus Justice Hall referred instead to the "retention ratio", that is, the percentage by which the basic cost of medical services must be increased to achieve the advantages of insurance. A "good" plan, from the perspective of both providers and patients, is one which minimizes the retention ratio, the cost of insurance per se, such a plan also maximizes the loss ratio.

The Commissioners concluded that private, for-profit insurers operated under incentives which tended to increase this form of overhead cost, adding to the expense of health care without adding to the resources available to provide it. High retention ratios (low loss ratios) were not an aberrant result of inefficiency, or a transient effect of small scale, but a fundamental characteristic of (successful) private insurance. This inherent tendency is strongly reinforced in a competitive environment with multiple insurers, in which the costs of intensive marketing and of increasingly careful risk selection must also be found out of the retention ratio (see also Evans, 1983). Regarding the costs of the insurance mechanism as unproductive overhead, they recommended centralized, non-profit administration in order to minimize them.

This recommendation has turned out to be quite perspicacious. The overhead cost of administering the public system in Canada are difficult to determine with precision, but are generally agreed to be in the neighbourhood of five per cent or less of payments to providers. As a proportion of national income, the costs of health care prepayment and administration have remained roughly constant for the last thirty years.

In the United States, by contrast, the costs of the insurance mechanism itself have escalated dramatically. The American payment process has become increasingly complex, as payers are making increasing efforts to minimize their own outlays by passing the costs on to someone else. Governments have pushed more of the costs onto employers; employers and insurers are trying to push costs back onto patients; the "uncompensated" costs of indigent care which hospitals have traditionally pushed onto private insurers, are being pushed back to them; and payers and providers are struggling over the price and use of services in individual cases, a costly, frustrating, and mostly ineffective process. It has become correspondingly more and more expensive just to push around the pieces of paper associated with providing and paying for care - to the considerable profit of lawyers, accountants, consultants, and administrators.
Costs of Insurance and Administration
As Share of GNP
Canada and U.S., 1960-1989

1987-1989 data are preliminary
Nor do the administrative costs of insurance and prepayment tell the complete story. The administrative costs borne by hospitals and physicians' offices have gone up rapidly as they attempt to cope with an increasingly complex payment and regulatory environment. Thus a significant proportion of the recorded expenditures for hospital and medical care, are in fact costs generated by the payment mechanism, though not included as explicitly reported costs of prepayment and administration. An increasing share of the sums Americans think they are spending on hospital and medical care, are going in fact to pay for administrators, accountants, lawyers, public relations specialists, and other persons whose services are not usually considered as contributing to the health of patients. The most recent estimates of the extra cost of administering the American system, relative to a Canadian-style approach are between $90 and $120 billion per year. (Woolhandler and Himmelstein, 1991).

These ballooning costs of the insurance process - all those accountants and lawyers - are leading increasing numbers of American physicians, as well as payers and patients, are beginning to believe that they might be better off under a Canadian system. Health expenditures in the United States keep going up, but providers feel - rightly - that their share is not going up as fast. Yet they are bearing the full brunt of the various measures intended - so far unsuccessfully - to limit cost escalation.

Of course providers have always preferred non-profit administration. The Blue Cross/Blue Shield plans were originally established by hospitals and medical associations in the United States. What they did not want, however, was a single non-profit payer, negotiating on behalf of the public generally rather than under provider control. And officially, they still do not (Todd, 1988). The Canadian form of non-profit administration comes in combination with "socialized insurance" - sole source payment, by an agency with both incentives and authority to try to keep down the costs of care - provider incomes - as well as the costs of insurance.

But if the alternative, a fragmented payment system, inevitably leads to escalation of total health expenditures, and even more rapid escalation of the costs of the insurance mechanism, combined with ever more onerous interference from regulatory agencies and private payers, and a less and less satisfying practice environment, then perhaps the Canadian form of payment might not be so bad. An increasing number of Americans - public bodies, private individuals, and even physicians, are coming to support some form of universal public insurance (Blendon, 1989; National Leadership Commission, 1989; United States GAO, 1991). The American Medical Association may still be bitterly opposed to what they continue to describe, incorrectly, as "socialized medicine", but the American College of Physicians - the second largest organization - now favours public insurance.

On the other hand, in Canada the question is beginning to be raised as to whether administrative expenses might not be too low; one observer has coined the term "administrative anorexia" to describe the attitude of provincial governments and their agencies towards spending on management.
A recent analysis of the Canadian system advances the thesis that, while not underfunded - indeed in total almost certainly overfunded, it is very seriously undermanaged (Rachlis and Kushner, 1989). Still others refer to it as "over-administered but under-managed". The distinction is important.

Traditionally, insurers simply paid whatever bills were generated by the health care system (or refused to pay them, leaving the "insured" individual with the liability). Physicians and other professionals determined the care that was needed by "their" patients, and either provided it or directed others to do so. Administrators ensured that the necessary facilities, equipment and personnel were available to carry out the directions of the professionals. But they did not "manage" in the sense of deciding what care should be provided, or how, or how its effects should be evaluated - these were professional questions. Administrators were senior support staff; they did not define or direct the fundamental tasks of the organization. The payers simply wrote cheques as requested, and raised their premiums as necessary.

Management, by contrast, involves deciding what care should be provided, under what circumstances, by reference to its expected or observed effects. It also involves determining how the organization will carry out its tasks, what is the most efficient mix of personnel, equipment, and facilities. Who shall do what, and with which, and to whom? These decisions are jealously guarded by professionals, as central to their autonomy. But they are often made by default, with no accountability to anyone else, and the evidence is that they are not made very well. A great deal of ineffective or otherwise inappropriate care is provided, and produced in unnecessarily costly ways - bad management.

These are the same issues as underly the debates over accessibility - which services are worth paying for, for whom, and what information and processes of analysis are needed in order to decide?

It must be emphasized, however, that these are quite different from the problems facing a private insurer, and which generate a significant part of the overhead costs of private, for-profit insurance. The private insurer is forced by the laws of the competitive marketplace to devote a great deal of effort to determining who not to insure - the worst risks. The private insurance market does not, cannot, cover those in most need of care.20

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20 Unless they happen to be quite well off, which in general they will not be, because illness is correlated with poverty, not wealth. The tens of millions of Americans who are uninsured, or have grossly inadequate coverage, are not an unfortunate aberration or oversight, but rather a natural and inevitable outcome of the operation of competitive forces in a private insurance market. This point has been made very clearly by Fein (1986), who illustrates it through the history of private health insurance in the United States.
Since the universal public system responds to an explicit society-wide political choice that everyone is to be covered, this problem of identifying individual risk status disappears, and along with it the whole complex apparatus of rate-making and policy design. The private marketplace generates a multiplicity of different types of coverage - far beyond the capacity of most purchasers to comprehend - in order to minimize the extent to which those in low risk categories pay to support those at high risk. But the public insurance system expresses the community's decision to do precisely that, to use the resources of the healthy and wealthy to support the poor and ill. So the principal services of the traditional private insurance sector are, literally, worthless, because their "product" is not what the community wishes to buy.

In its place, however, is the problem of determining the needs and priorities of those to be cared for, and the effectiveness of the services offered. Provincial governments are clearly responsible for purchasing care on behalf of their populations. Achieving "value for money" in this process may well require a build-up of managerial capacity, and the creation of new administrative structures, within the overall framework of non-profit administration.
PART 3: MANAGING THE SYSTEM, AND COPING WITH CHANGE

There are several paradoxical features to the Canadian experience, not least of which is the nature of the political controversy which seems always to surround it. On the one hand, as emphasized above, there is absolutely no doubt about the strength of the public commitment - by ordinary citizens, politicians, and even most providers - to the fundamental principles of the system. There is no support for, and indeed would be overwhelming opposition to, any overt attempt at abandonment or major revision of those principles.

Yet on the other hand, the functioning of the health care system is constantly in the forefront of public debate, and its management is by far the most demanding responsibility, not just in dollars but in terms of political and technical skills, carried by each of the provincial governments. Ministers of Health, and premiers of provinces, are held accountable in the provincial legislatures and in the press for individual problems and misadventures which occur in the operation of the health care system.

The management of the health care system in Canada has thus become politicized to an extreme degree. And while the results of such political management are generally agreed to be relatively satisfactory, it does carry with it certain characteristic limitations. On the other hand, it is not clear any of the other industrialized democracies, even the United States, is so very different from Canada in this respect. All such countries, except the United States, have collective systems for financing all or most of their hospital and medical care, and thus must deal politically both with decisions as to who shall be permitted to perform, and paid for, what sorts of services, for whom, and with the determination of the relative incomes of those persons who provide health care services.

And even in the United States, the critical decisions are political; the market is much more prominent in rhetoric than in reality. The principal difference is that the key political decisions tend to be more decentralized and hidden, whereas in Canada they are centralized and played out in the full glare of the media (Evans, Lomas et al., 1989). European systems tend to be more similar to the Canadian, in that the political decisions tend to be centralized, but they appear to be less open to the public than in Canada.

At present, the health care policy agenda in Canada is being driven by a set of interlocked problems, none of which are particularly new, or peculiar to Canada. On some, there is evidence of progress, on others we can see that present problems are the result of past policy failures, which being left uncorrected, will generate continuing difficulties in the future. (But at least our grandchildren will not be bored.)

3.1 Controlling the Escalation of Health Care Expenditures

The first problem area, Cost Control, faces every society in the industrialized world, with the possible exception - so far - of Japan. It
may be that if the modernization and growth of a country's general economy can continue to outstrip that of its health care system, it need not be overly concerned with health care cost control. This has not, however, been the situation in North America or Western Europe, where all countries have had to wrestle, over the last decade or more, with the problem of moderating the growth of health spending in order to protect resources for other social and private priorities. And any country modernizing its health care system would do well to consider carefully how it will deal with the inherent tendency of such systems to unlimited expansion, in the absence of strongly enforced external constraint (Evans, 1990, 1991).

Within the last five to ten years, however, all such societies except the United States appear to have found some response, if not necessarily a permanent solution, to this problem (Schieber and Poullier, 1991). Several countries have actually reduced their shares of national income spent on health care, in some cases quite significantly.21 The process of control, in every country, has been accompanied with considerable difficulties and political conflict, and it is always possible that the health care system will succeed in breaking out of the controls which each society has placed on it, but for the moment a degree of stability prevails.

The processes whereby the provincial governments in Canada have imposed these controls, over a period of nearly twenty years with the exception of the "recession breakout of 1982, are three in number.

First, as noted above, the nature of the Canadian payment system permits it to function very economically in terms of administrative costs, and these have not been rising over time. Ironically, it appears that the American attempt to create more "competition" in health care has added significantly to these unproductive expenditures.

Secondly, the fee schedules negotiated between the medical associations and governments in each province have escalated much less fast than fees in the uncontrolled American environment. At the same time, the elimination of extra-billing has prevented physicians from exploiting this alternative form of fee inflation. Over time, fees in Canada have risen at a rate more or less in line with general price inflation; when physicians can set their own fees freely, fees rise substantially faster.

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21 Figure 1 above show Canada's relative ranking in per capita cost at the beginning and end of the 1980s - far below the United States, but above all other OECD countries. Certain countries - Germany, Sweden, the Netherlands - have moved down in relative position, indication lower than average cost escalation. But as Figures 2 and 3 show, the American "cost explosion" has largely been contained in Canada. These data have been disputed by, among others, the Health Insurance Association of America, which is quite understandably concerned that the Canadian aproach might be adopted in the United States. But the difference is real: see Barer, Welch and Antioch (1991), and Evans, Barer and Hertzman, (1991).
Limiting utilization of fee for service medicine

In response, physicians in Canada do appear to have increased their volumes of billings per physician somewhat faster than in the United States, but they have not been able to offset fully the slower increase in fees (Barer, Evans and Labelle, 1988). An important contributor to the control process appears to be the fact that fee schedules limit the reimbursement of diagnostic services outside hospitals - most physicians cannot simply set up their own laboratories, for example - and also prevent implicit "fee splitting" between laboratories and referring physicians (Reinhardt, 1988).

These controls over the tendency of physicians to engage in "procedural multiplication" and "strategic billing", particularly when fee inflation is contained, are by no means complete, and any particular form of control tends to erode over time. Canadian provincial governments are increasingly exploring ways of imposing more explicit "caps" on total outlays for physicians' services. Two provinces - Quebec and British Columbia - have already done so, and it is likely that more will follow (Lomas et al., 1989).

Such caps can take a variety of forms. The simplest, direct pro-rating, establishes a fixed total of funds to be paid to physicians in a given time period. This is then compared with the total dollar value of billings or reimbursement claims submitted by physicians for services provided during that period, and the ratio between money allocated and total claims submitted is multiplied by the value of each physician's claims to determine how much he or she will actually be paid. The payments will be greater or less than the amounts submitted, depending upon whether the total of claims is less or greater than the amount budgeted. A version of this process has been used for a number of years by the German sickness funds; and cost escalation in Germany has been less rapid, over the last decade, than in most other OECD countries.

Pro-rating has certain technical problems, which are not too difficult, but global pro-rating also some serious incentive problems, insofar as it tends to penalize more conservative and cautious physicians who fail to exploit the system to the utmost. A more elaborate and sophisticated system with separate but linked regional and specialty caps has been developed which has positive incentives for regional allocation of services, for conservative use of referrals, and for collective decision-making by physicians over the appropriateness of care (Evans, 1988b), but this has yet to be tried in practice.

The caps which have been imposed in the Canadian provinces involve setting upper limits for the increase in use in each time period, at the time of the negotiation of the fee schedule. If actual use of services - amounts billed at the new fees - increases more rapidly than the target rate, the excess is deducted from payments in the next period (Lomas et al., 1989; Barer et al., 1988). But the caps have not always been completely "hard", because the agreements often provide for only part of any excess above targets to be paid back by physicians, and because the payback process
becomes entangled in the negotiations for the next fee agreement, rather than being automatic.

But the control of costs is also directly linked to manpower policy, because the volume of physicians' services billed rises more or less in proportion to the increasing numbers of fee for service physicians. As noted below, manpower policy has worked in opposition to cost control, by supporting a growth in physician supply well in excess of the rate of growth of the population. This places continuing upward pressure on costs; but it has been extraordinarily difficult to mobilize political support for reducing the number of training places.

Finally, a very important part of the control of health care costs has been the system of global budgeting for hospitals, which enables this component of the health budget to be subjected to absolute "cash limits". The result has been a steady decline in acute care utilization, which nevertheless remains high relative to United States experience, and a much less rapid proliferation of new and very expensive high technology interventions. Canadian provinces do acquire the most recent technology, but such equipment tends to be confined to the teaching hospital centres, and does not proliferate throughout the regional hospital system or into free-standing facilities. Thus the availability per capita of such equipment tends to be lower than in countries such as the United States, Germany, or Japan, and this is another significant contributor to the moderation of cost escalation.

3.2 Health Care Use by the Elderly

The Aging of the Population is perhaps the most frequently cited source of serious problems, now and particularly in the future, for the Canadian and most other health care systems. Yet it is the area in which the rhetoric is in fact most misleading. The usual argument is that elderly people require more, and more costly, health care services, on average, than do younger people. At the same time, it is notorious that the proportion of elderly, and particularly very elderly, people in the population is growing, as birth rates have fallen and life expectancies have risen. Both these observations are true. But the common conclusion, that the costs of caring for the elderly will therefore necessarily exceed the willingness or ability of industrialized economies to pay for them, does not follow. It is particularly misleading, indeed flatly false, to claim that such demographic trends are the source of the cost pressures being felt in health care today.

A good deal of research has been done on the changing patterns of care of elderly people in Canada, and it is all consistent. The aging of the Canadian population, and we believe of all other populations in the industrialized world, is a very important phenomenon over a time span of decades. But its effects on health care use are very slow. In Canada, the aging of the population would add about one percent per capita per year to health costs, if the utilization patterns at each age remained unchanged, and only the population age structure changed (Woods, Gordon, 1984). Over thirty, or fifty, years, this is a substantial impact. But
one percent per capita per year is well within the normal, or at least historical, economic growth rates of industrialized economies, and could easily be accommodated with a constant share of such growth being devoted to health care.

But the age-specific use rates are not remaining constant (Barer et al., 1987). Hospital in-patient days per capita, for example, are increasing for elderly people while dropping rapidly for the rest of the population (Evans, Barer et al., 1989). Average physician billings per person are rising for the whole population, but much faster among the elderly than among the rest (Barer et al., 1989). In-hospital procedures are likewise rising fastest in this age group. And these changes in relative use rates by the elderly and non-elderly populations are observed after adjustment for the changing age mix within each group; they are not an artifact of the increasing average age of the elderly themselves.

Thus elderly people are accounting for an increasing share of our health care effort and resources. But their growing numbers - and average ages - make a relatively small contribution to this increase. The much more important factor is that, over time, ever more is being done for, or to, each elderly person. They are being subjected to many more, and more intensive, interventions. And the effectiveness of these interventions is often unproven, particularly for the older age groups who are less often enrolled in clinical trials.

Thus the "Aging of the Population", which claims priority of place in so many discussions of health policy, is largely a false issue. The real question is what benefits are being derived from the services which are being applied in increasing numbers to the care of the elderly. That takes us on to the questions of technology, of effectiveness and appropriateness of care, and indirectly to issues of manpower or personnel. The demographic transition, at least as it applies to the past decade and the next, is in fact a smokescreen which obscures more fundamental questions of the basis on which utilization decisions are made, and the costs and benefits of the results.

3.3 Absorbing New Technologies: When, Where, and For Whom?

Coping with the Extension of Technology is simply part of this more general set of issues. Technology per se is neither good nor bad; new knowledge and capabilities in principle merely expand our range of choices. The rhetoric surrounding technology often suggests that we are somehow compelled to apply whatever is discovered, at whatever expense. But the technology does not define its own range of application. Many, though not all, new technologies have the capability to reduce significantly the costs or other burdens associated with particular health problems - if conservatively applied, and limited to areas of demonstrated effectiveness. The real problem of a trade-off between technological "advance" and cost control arises when new and expensive techniques (or for that matter old and not so expensive techniques) are employed and paid for in circumstances in which there is no evidence that they will do any good.
Thus the problem posed by new technology is primarily evaluative and organizational, rather than economic. First, how do we determine whether the technique does more harm than good, and for which patients? This requires careful analysis of the biological effect of the associated interventions, but also requires developing techniques for eliciting the preferences and values of potential patients. Whether an intervention does more harm than good depends on both - what is right for one may be inappropriate for another. (But no one needs interventions that do not work!) And second, once such information is available - "technological assessment" in a broad sense - how do we ensure that utilization decisions by providers and patients actually reflect this information?

A number of students of the benefits and costs of new technology have concluded that there is ample capacity, in the health care systems of industrialized societies, to support all the new technology that one might want - if one could get rid of the minimally effective, useless, and harmful interventions now being provided and paid for. The problem is to find an organizational framework, and decision processes, which will lead to this result.

Coming back to the Canadian experience with cost control, it has been noted that the intensity of servicing, or the inflation-adjusted expenditure per person, has risen relatively slowly in Canadian hospitals. The control of hospital costs through global budgets, has been associated with a slower rate of increase in the number of procedures performed, and/or their expense, than in the United States. Technology has proliferated more slowly in Canada.

This raises the question of the appropriateness and effectiveness of the care being provided. Are Canadians being denied potentially effective treatments which would increase the length and/or improve the quality of their lives? Or are they being protected against the over-enthusiastic application of interventions which would be useless at best, quite possibly harmful, and certainly expensive? One can find advocates of both points of view.

What can reasonably be said is that the control of global budgets rests on the assumptions (i) that physicians and hospital administrators, when they do not have enough resources to do all that they would like to do - for whatever reason - react by eliminating the least useful or most harmful services first, and (ii) although they will always claim the contrary, they really do have enough resources to do all that is worth doing, and probably more besides, and finally (iii) if (ii) should cease to be true, other sources of information will bring this fact into the open, so that budgets can be adjusted as needed.

On the other hand, it must be admitted that detailed information on the effects both of the care that is being provided in Canadian hospitals, and of the care that is not being provided, is remarkably scarce (as it is in most other countries) and we might be well advised to study this area much more closely - the same point which emerges when one looks closely at the changing patterns of care of the elderly. But the growing evidence of
very substantial inappropriate, and actually harmful, use of "high
technology" procedures in more richly endowed United States emphasizes
that the relative limitation placed on the diffusion of technology by the
Canadian funding system may very well be a benefit of that system,
although critics present it as a negative feature.

3.4 Health Care Personnel: Capacity and Need

Health care policy in Canada has been least successful in the formulation
and execution of Manpower Policy. It is widely, though not universally,
believed that Canada has a surplus of physicians and a shortage of nurses;
the difficulties in both areas are traceable to inability to respond to
obvious and well-documented facts.

There are at present about sixty thousand physicians in Canada, roughly
one for every 450 people. The ratio of physicians per capita has doubled
in the last thirty years, and is currently increasing about two percent
per year. This expansion places continuing upward pressure on
expenditures for physicians' services. Independent private practitioners
reimbursed by fees for their services appear always to be able to identify
enough unmet needs, such that total billings (adjusted for inflation) have
risen at or somewhat above the rate of increase in physician supply.
There is no evidence, in the aggregate data, of a saturation point beyond
which additional physicians result in falling average workloads and
incomes.\footnote{One might think that this was peculiar to a fully insured
environment, but in fact the same pattern is observed even in the United
States, where a large proportion of physicians' services are paid for out
of pocket by patients.}

But the increase in physician numbers also places pressure on the
available hospital bed space and associated facilities which physicians
use in their practice, and without which their billing opportunities are
much reduced (Barer, Gafni and Lomas, 1989). As the "physicians per bed"
ratio rises, each physician perceives a more and more severe shortage of
capacity, available to him (or increasingly, her), even though the
capacity per person cared for remains high.

Bad forecasts make bad policy

No one planned this massive expansion; it was an accident resulting from a
forecasting error followed by a stubborn refusal to change course.
Population forecasts made in the early 1960s were the basis for a large
increase in medical school capacity over the next decade. But those
forecasts were made just before the historic collapse of the birth rate.
By the early 1970s it was obvious that our medical school capacity was far
beyond the needs of a low-fertility society. But there were too many
powerful interests at stake to permit a reduction. Instead, medical
school representatives clouded the political landscape with a variety of
false claims (documented and demolished in Lomas et al., 1985). By 1991,

\footnote{One might think that this was peculiar to a fully insured
environment, but in fact the same pattern is observed even in the United
States, where a large proportion of physicians' services are paid for out
of pocket by patients.}
the actual Canadian population is nearly ten million people lower than the forecast level for which our current training capacity was built.

The status quo thus has no logic or legitimacy in its origins, but it is entrenched. Some reductions in training places are now occurring, but slowly and painfully. Universities in Canada are directed by independent Boards of Governors, and while they derive most of their funding from government, it does not come primarily from ministries of health. Medical schools must be bribed or browbeaten into reducing their training places, probably with guarantees that their budgets will not be cut, and perhaps with increased research funding. But this requires inter-ministerial co-operation.

The benefits of reduction, in terms of costs saved by payers, accrue over years or decades, and may accrue in another jurisdiction, since physicians can move freely from province to province. But the political costs are immediate, because the general population, encouraged by the representatives of medical schools, do not support reductions. They just do not want to pay for the increased numbers of doctors!

 Provincial governments are, however, increasingly exploring policies to try to protect themselves from the fiscal consequences of past increases, and this is drawing their attention to the root of the problem (Barer, 1988). Attempts to place global caps on payments to physicians, imply that they now have an increasing stake in helping to control the increase. Moreover, ministries of health have much more influence over specialty training programs, because these are directly funded through teaching hospital budgets. By reducing funding for residency positions, and perhaps training nurses or other personnel to provide the support services for which fee for service practitioners now rely on residents, one could both hold down the rate of specialization, and also close off a "back-door" route by which immigrant physicians still enter Canada in significant numbers.

Inter-provincial committees of health ministers and their senior staff have for some years been working to find co-operative ways of addressing the problem, and in the summer of 1991 they received a major commissioned report (Barer and Stoddart, 1991) addressing all aspects of the physician manpower issue. Something may yet happen.

Nursing presents the opposite picture, with widespread claims of growing shortages. But in fact, shortages and surpluses alternate from year to

23 No one in his right mind has ever suggested that there is an obligation on the public to train as a physician anyone who might wish to become one, and qualify for entry. The basic idea that a public educational and payment system should recruit, train, and reimburse the numbers of personnel required to meet the needs of the population, is virtually unquestioned, in principle. In practice, however, the needs have been redefined by professionals to justify a level of capacity which arose by accident.
year, or even month to month, depending upon the provincial government electoral and budget cycle. When funds for hospitals are plentiful, there is usually a "shortage" of nurses to meet the new positions created. When fiscal times are tougher, the unfilled positions disappear. The supply response is less flexible than hospital budgets.

When nurses and their representatives refer to "shortages", however, they mean not that positions are unfilled, but rather that hospital budgets should be increased to hire more nurses. The "shortage" is relative to the level of servicing which nurses believe they should be paid to provide, not the actual demand by employers.

Over the longer run, however, there are larger forces at work. The collapse of births in the mid-1960s has led to a sharp reduction, in the late 1980s, in the age groups from which nursing has traditionally recruited. And alternative career opportunities for females have greatly increased. In total, nursing manpower has barely kept up with population growth, while the aging of the population has much more impact on needs for institutional care than for physicians' services.

This problem is exacerbated by the persistence of traditional forms of organization in hospitals, where nurses employed by the hospital care for patients who "belong" to the physicians who admit them. This leads to inefficient use of both hospitals and nurses; hospital use rates in Canada are much higher than necessary. It also limits career opportunities and professional development in nursing, contributing to growing labour unrest.

In the long run, it seems inevitable that we will have fewer, more highly trained and paid nurses, and fewer people will be in hospital. But how do we get from here to there? At present, the professional objectives and educational philosophies of nursing leadership seem directly at odds with the needs of the health care system.

The lack of co-operation between the educational and health care systems, located in different ministries and institutions, with different cultures, objectives, and philosophies, has led to serious inconsistencies in health manpower policy. And faulty manpower policies can foreclose the possibilities for improved management of health care delivery, sometimes for decades.

3.5 How to Decide What to Do

Throughout the discussion above, we have noted that a number of apparently separate problems - population aging, the extension of technology, manpower - actually reduce to special cases of the more general issue - what sorts of health care services do we wish to have produced, and for
whom?24 These questions, as noted, ultimately turn on a combination of technical and value information - "What will particular services actually do, in the way of good or harm?" and "What do the rest of us, as both patients and payers, want?"

To date the Canadian health care system has addressed these questions only indirectly. "All medically necessary" services are free, implying that effectiveness, somehow defined, is the over-riding criterion. But this has been determined implicitly, as whatever a physician is willing to offer and a patient to accept. What we have discovered, as has every other country in the industrialized world, is that (i) the indirect definition of "need" is infinitely expansible within the relevant range, particularly for elderly people, and (ii) overall utilization rises with the availability of facilities and personnel, and tends always to press against any resource constraints, but (iii) the aggregate levels and patterns of utilization which result are highly variable, and bear no identifiable relation to any external definition of the "needs" of the population served.

The Canadian response has been to try to impose capacity constraints on the availability of facilities, sources of payment, and (much less successfully) personnel. The assumption, as noted above, is that when subjected to these constraints, the providers of health care will themselves choose to provide the services which respond to the greatest needs. Thus the payers for services can avoid the very difficult and politically very dangerous task of establishing explicit priorities and protocols, and the fiercely defended autonomy of the physician need not be challenged.

This approach is slowly changing, however, in the face of accumulating evidence that patterns of care use in Canada bear no more systematic relation to indicators of need than they do in any other jurisdiction, and more important, under the increasing pressure for more resources from the providers of health care themselves - the consequences of the physician supply increase and the extension of technology. As the relatively arbitrary limitations on facilities and resources are challenged more and more intensely by providers, provincial governments are becoming increasingly interested in the extensive research evidence of ineffective and inefficient care delivery as a basis for counter-attack.

This last point is most important. The research evidence of inefficiency and ineffectiveness of care provision, measured relative to the scientific basis for judging what interventions work, and how they might be carried out, has been available for many years - though it is certainly growing in scale and sophistication. But for most of the history of the Canadian

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24. The struggle over how much producers should earn - income shares - is largely though not entirely a separate question, though providers try hard to confuse the two. It is commonly claimed that higher (lower) fees and wages will lead to better (worse) quality of care for patients, though the mechanisms are not always clear.
programs, at least, and apparently in Europe as well, the cruder forms of cost restraint which raised no awkward questions about why physicians and others do what they do, represented the politically most comfortable compromise.

That compromise appears finally to be breaking down, and governments in a number of countries, acting as regulators and payers on behalf of their citizens, are beginning to address explicitly the question of "how medicine should be practiced". As noted above, in Canada this process is occurring through expert committees appointed by governments and professional bodies to wrestle with priority setting and protocol definition, within the limits of globally fixed budgets. This is a major step forward from the historic policy of implicit constraint through deliberate limits on the availability of facilities, but it is too soon to tell how successful such processes will be, and particularly whether they will be able to sustain the inevitable political counter-attack. But at least the questions are being raised at a much higher political level than ever before.

3.6 From Sickness Care to Health: Some Missing Links

The Canada Health Act of 1984 defines the objective of Canadian health care policy as "... to protect, promote, and restore the physical and mental well-being of residents of Canada, and to facilitate reasonable access to health services without financial or other barriers" and refers to "outstanding progress" through the system of insured health services. But it also declares that further improvements will depend on a combination of improved individual lifestyles, and "collective action against the social, environmental, and occupational causes of disease." These themes reiterate ideas expressed in a document issued in 1974 by the federal Minister of National Health and Welfare, Marc Lalonde, "A New Perspective on the Health of Canadians".

Equalizing access to health care, or at least removing the financial barriers - and significantly increasing the overall quantity of resources available - has not equalized access to, or at least the experience of, health, across the population. There remain significant inequalities in life expectancy and health status across different socio-economic groups. Furthermore, there are obvious sources of mortality and morbidity which are simply beyond the reach of health care services as conventionally defined. A public health policy, as different from a health care policy, would have to go much deeper into the determinants of health and illness,

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25 In Canada, it is taken for granted that these questions will be addressed through some negotiation between governments, representing the general public as payers and patients, and the providers of care, also representing the public as patients and themselves as earners. New institutions may be developed to assure a more effective representation of both patients and the general public, but there is little interest in private markets as ways of improving efficiency and effectiveness. The United States experience is too close and too vivid.
and consider - and carry out - a much wider range of interventions than simply the expansion (or contraction) of particular health care services.

This is clearly recognized within the federal Department of National Health and Welfare - the Ottawa Charter of 1986 was a strong affirmation of support for the World Health Organization Health for All initiative. Most provincial Ministries of Health have a similar understanding, although they are so heavily involved in the day to day and year to year operations of the health care system that they do not always have the luxury of pursuing the broader issues. In general, however, these broader issues of inequalities in and determinants of health have been honoured with much rhetoric - and a non-trivial amount of careful thought - but very little money.

The problem is simply that the relentless pressure for expansion from the health care system, independently of any contribution it may or may not be demonstrated to make to the health of the population, absorbs the lion's share of both current resources, and any additional that may become available. Thus cost containment in health care becomes a pre-condition for any new initiative in other areas of health. By a cruel irony, an over-extended health care system may become a threat to health.

Nevertheless, despite its relatively limited constitutional role, the federal government is clearly pressing ahead with its concerns for the promotion of health, whether in or particularly outside the health care system. In particular, it has launched a number of surveys to accumulate a much wider body of data on the health status of the Canadian population; until recently we knew a great deal about utilization and costs of care but very little about health. Provincial governments' concerns for improved efficiency and effectiveness, though driven primarily by cost concerns, also lead quite naturally into questions as to the relative effectiveness of health care as against other public interventions in pursuing the central objective - the health of Canadians.
In summary, the Canadian approach to health care funding has been very successful in equalizing access to health care services, though less so to health. This appears to be a common finding in the industrialized countries, reflecting the fact that population health is not determined simply by the availability or use of health care. The health status of the Canadian population, insofar as that is known (which is not very far) compares well on the usual indicators of life expectancy and infant mortality with the rest of the industrialized world, and continues to improve.

The public insurance system has not only assisted access to health care, it has also played a very important role in "nation-building" and community solidarity, as it emphasizes a fundamental equality among citizens. Greater wealth or position buy many things, but they do not buy more or better health care; in that we are all equal. Moreover the economic burden of this system is shared, through the general tax system, according to the ability to pay of citizens. Since there are no direct payments, people who must bear the burden of illness and injury do not have to carry an additional economic burden as well. No one in Canada fears economic ruin from the cost of health care, and no one depends on "charity", whether public or private. The financing problems, and associated negotiations, are completely removed from the shoulders of individual citizens.

Going beyond assuring access, and improving the lives of individual citizens, the Canadian system has also managed to contain the costs of health care for an extended period of time. This is a crucial test of the sustainability of a funding system; disequilibrium requires change. Furthermore it has done so in a way which has reconciled the interests of citizens as payers, and citizens as patients, and is consequently overwhelmingly popular politically. It is less popular with physicians, at least officially, though strongly supported by hospitals and other health occupations.26

The political price of cost containment, however, is rising. The severe recession at the beginning of the 1980s was associated with a sharp increase in the share of national income going to health care - because income fell and health spending did not. Stability has been re-established, but in the new low-growth environment this requires even tighter controls. A stable share of a constant total income is much less acceptable to providers, and the pressure for "More!" is becoming

26 It is probable that the inherent conflict of economic and professional interest - both income and autonomy - is so sharply drawn that no system of funding which meets the concerns of the rest of the community will ever be wholly acceptable to physicians, and conversely. Certainly the Canadian system was established over their opposition. A search for a national system acceptable to all parties would probably be a nonsense exercise, a proposal to do nothing.
increasingly acute.

But on balance, after more than twenty years of experience, it appears that even most physicians working in the Canadian system prefer it to the known alternatives - they would just like more money (and more hospital facilities and more equipment, and the right to extra-bill patients, and...!) Similarly, nurses and other hospital workers strongly support the existing system, but believe that its funding should be greatly increased. Taxpayers are less enthusiastic. (Patients generally believe whatever they are told by providers.)

On the basis of this experience, which is not so different from that of a number of European countries, we conclude unequivocally that centralized, public funding systems "work", although they will require an increasing degree of explicit collective intervention in the determination of the content of medical practice. Whether this will be "public" or "private", or more realistically what should be the balance between the two, depends upon whether the medical profession can bring itself to develop and enforce scientifically based standards upon its members, or whether the public sector will have to take on this role by default.

On the other hand, we conclude equally unequivocally from the comparative United States experience that private, or "pluralistic" funding systems do not "work"; they produce neither effective health care, nor equity, nor public satisfaction, and cannot even meet the most fundamental test of stable and sustainable cost. One cannot rule out the possibility that some pluralistic system might be developed in future which would be capable of harnessing competitive forces to improve health care system performance. But at present most such systems exist only in the imaginations of those with an over-riding ideological commitment to the private marketplace - they cannot be shown to have been seriously tried, much less to have succeeded, in the real world.

There are, of course, examples of thoughtful and carefully worked out competitive proposals which take account of the sources of failure in ordinary conceptions of "market" systems, and attempt to develop realistic ways of dealing with them (e.g. Enthoven and Kronick, 1988). These may be attractive where the status quo is considered intolerable, but such admittedly imperfect but battle-tested systems as the Canadian are ruled out on ideological grounds. But even these are untried alternatives; moreover the feasibility of their full implementation in a highly adversarial environment is very far from clear.

Where the Canadian system has most clearly fallen short, is its inability to develop a coherent and consistent manpower policy, and this is an expensive failing. Nor has it yet made much progress on the promotion of efficiency and effectiveness - the United States appears to be far out in front of the rest of the world on these issues (yet unable to draw the benefit from its superior knowledge and technique). Rachlis and Kushner's assertion that the system is undermanaged is undoubtedly correct, so that waiting lines exist and patients may sometimes suffer, not because of a scarcity of overall resources, but because those available are mis-used.
This is in part the price of professional autonomy.

And finally, along with most of the rest of the world, we do not yet know nearly enough about the determinants of health, and why some people are healthy and others not. But we recognize the problem, and we are working on it.
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